STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. BUILDING _____ B. WING _____	C 09/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN MANOR OF PAINTSVILLE	1025 EUCLID AVENUE PAINTSVILLE, KY 41240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey (KY19088) was initiated on 09/25/12 and completed on 09/26/12. The complaint was substantiated with deficient practice identified at "J" level. Immediate Jeopardy and Substandard Quality of Care were identified at 42 CFR 483.25 Quality of Care (F333). On 08/07/12, a physician's order was obtained to decrease Resident #1's Coumadin (anticoagulant reduces formation of blood clotting factors) from 5 milligrams (mg) to 4 mg every night. However, the facility failed to ensure nursing staff followed the facility's protocol for electronically entering a change in medication orders. Nursing staff entered Resident #1's new Coumadin order and "modified" the existing Coumadin order, which changed the time for the medication to three times a day, instead of every day as ordered by the physician. The computer entry for Coumadin generated a new Medication Administration Record (MAR) for Resident #1 which indicated the resident's Coumadin was to be administered three times a day, instead of once a day at night. Resident #1 received Coumadin 4 mg on 08/08/12 at 9:00 PM; on 08/09/12, at 8:00 AM, 5:00 PM, and 9:00 PM; and on 08/10/12, at 8:00 AM, 5:00 PM, and 9:00 PM. On 08/10/12, at 11:56 PM, a Prothrombin Time (PT) and International Normalized Ratio (INR) (a blood test used to measure the time it takes plasma to clot) was obtained with critical results of a PT of more than 143 and an INR of 13.75 (reference PT of 9.5-11.8 and an INR of 0.9-1.1). Resident #1 was transported to the hospital and diagnosed with Coumadin Toxicity and Anemia. At the hospital, Resident #1 received two injections of Vitamin K	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. BUILDING _____ B. WING _____	C 09/26/2012

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F 000	Continued From page 1 (assists with blood clotting), five units of packed red blood cells, and two units of fresh frozen plasma. Resident #1 was readmitted to the facility on 08/15/12. The Immediate Jeopardy was identified on 09/25/12, determined to exist from 08/09/12 through 09/20/12, and was removed on 09/21/12. The facility completed corrective actions prior to the State Agency's investigation on 09/25/12; therefore, the Jeopardy was determined to be Past Jeopardy.	F 000		
F 333	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review, hospital record review, and facility policy review, it was determined the facility failed to have an effective system to ensure one of three sampled residents (Resident #1) was free of any significant medication errors. On 08/06/12, Resident #1's Prothrombin Time (PT) and International Normalized Ratio (INR) (a blood test used to measure the time it takes plasma to clot) was 31.7 and 3.2 (reference PT of 9.5-11.8 & INR of 0.9-1.1), which was elevated. On 08/07/12, a physician's order was obtained to decrease Resident #1's Coumadin (anticoagulant - reduces formation of blood clotting factors) from 5 milligrams (mg) to 4 mg every night. However, the facility failed to ensure nursing staff followed the facility's protocol for electronically entering a	F 333	Past noncompliance: no plan of correction required.	

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	185414	A. BUILDING _____ B. WING _____	C 09/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN MANOR OF PAINTSVILLE	1025 EUCLID AVENUE PAINTSVILLE, KY 41240

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F 333	Continued From page 2	F 333		

change in medication orders. When nursing staff entered Resident #1's new Coumadin order the existing Coumadin order was "modified," which changed the time for the medication to three times a day instead of every day as ordered by the physician. The computer entry for Coumadin generated a new Medication Administration Record (MAR) for Resident #1 which also indicated the resident's Coumadin was to be administered three times a day, instead of once a day at night. Resident #1's Coumadin container received from the facility pharmacy had the correct physician's order for once a day at night on the label. However, nursing staff failed to follow the facility's medication administration policy and failed to check the label on Resident #1's Coumadin against the resident's MAR. Review of Resident #1's MAR revealed the resident received Coumadin 4 mg on 08/08/12 at 9:00 PM; on 08/09/12 at 8:00 AM, 5:00 PM, and 9:00 PM; and on 08/10/12 at 8:00 AM, 5:00 PM, and 9:00 PM. On 08/10/12 at 11:56 PM, a PT/INR was obtained with critical results of a PT of more than 143 and an INR of 13.75. Resident #1 was transported to the hospital and diagnosed with Coumadin Toxicity and Anemia. At the hospital, Resident #1 received two injections of Vitamin K (assists with blood clotting), five units of packed red blood cells, and two units of fresh frozen plasma. The resident was readmitted to the facility on 08/15/12.

The facility's failure to ensure residents were free of any significant medication errors was likely to cause serious injury, harm, impairment, or death. The Immediate Jeopardy was identified on 09/25/12, determined to exist from 08/09/12 through 09/20/12, and was removed on 09/21/12.

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	185414	A. BUILDING _____ B. WING _____	C 09/26/2012

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F 333	Continued From page 3	F 333		

The facility completed corrective actions prior to the State Agency's investigation on 09/25/12; therefore, the Jeopardy was determined to be Past Jeopardy.

The findings include:

Review of the facility policy entitled "Administering Medications," revised February 2004, revealed the nurse administering medications was responsible to check the medication and the dosage scheduled on the resident's MAR to ensure they matched the label on the medication's container. The policy stated if there was any reason to question the dose or the dosage interval, the nurse was responsible to check the physician's orders for the correct dosage schedule. According to the policy, the nurse should read each medication container three times: (1) when taking the medication from the drawer, (2) before putting the medication in a container, and (3) when placing the medication back into the drawer. The policy also stated, "To assure administration accuracy, the nurse shall cross check the medication administration record with the label on the drug container."

Review of the facility policy entitled "Orders for Anticoagulants," revised April 2007, revealed an oral anticoagulant order specified to be given daily would be administered with the evening medications. Facility protocol revealed Coumadin was scheduled to be given at 9:00 PM.

Review of the facility policy entitled "Addendums, Amendments, Corrections, Modifications and Deletions in the Electronic Health Record," effective 06/05/12, revealed under the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. BUILDING _____ B. WING _____	C 09/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN MANOR OF PAINTSVILLE	1025 EUCLID AVENUE PAINTSVILLE, KY 41240

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F 333	Continued From page 4	F 333		

Modification section, "Physician's orders should not be modified. When a new order is received or an order is changed, the current order should be discontinued and the new order should be entered."

Interview conducted on 09/26/12, at 10:30 AM, with the Administrator revealed the nurses were instructed never to modify a medication order in the computer MAR system. The facility's protocol was when a nurse received a new medication order, the nurse was required to discontinue the previous order and enter a new medication order.

Review of Resident #1's medical record revealed the resident had a hospital stay from 07/12-25/12, and was diagnosed with Pneumonia, Methicillin Resistant Staphylococcus Aureus (MRSA) (a type of staph bacteria that is resistant to certain antibiotics) and Pulmonary Emboli (blood clots in the lung). The resident was readmitted to the facility on 07/25/12, with no orders for Coumadin and an elevated PT of 48.8 and an INR of 4.69 (reference PT of 9.4-11.4 and INR of 1.5-4.5).

Review of Resident #1's physician's orders revealed an order on 08/01/12, for a PT/INR to be obtained that day and to start Coumadin 5 mg every night starting that night (08/01/12).

Review of Resident #1's laboratory results on 08/02/12, revealed the resident had a PT of 12.2 and an INR of 1.2 and an order to repeat the PT/INR on 08/06/12. Resident #1's laboratory results on 08/06/12, revealed the resident's PT was 31.7 and the INR was 3.2 (higher than the normal value). Due to the elevated values, a physician's order dated 08/07/12, instructed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. BUILDING _____ B. WING _____	C 09/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN MANOR OF PAINTSVILLE	1025 EUCLID AVENUE PAINTSVILLE, KY 41240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 5	F 333		

decrease the Coumadin to 4 mg at night and to repeat the PT/INR blood test in two days.

Interview conducted on 09/26/12, at 9:50 AM, with Licensed Practical Nurse (LPN) #1 revealed she received the physician's order and wrote the order correctly on the physician's telephone order sheet, which was faxed to the pharmacy, and correctly documented the medication changes in the nurse's notes. However, LPN #1 attempted to take a shortcut when entering the new order into the electronic MARs on the computer. The interview revealed instead of discontinuing the current Coumadin order (as per protocol) and writing a new Coumadin order, the LPN modified the existing order. By modifying the existing Coumadin order, the computer's electronic MAR system reverted the time code for the medication from once a day at night back to three times a day.

Review of Resident #1's MAR revealed the resident received Coumadin 4 mg on 08/08/12, at 9:00 PM, as ordered by the physician. The review revealed on 08/09/12 and 08/10/12, Registered Nurse (RN) #1 administered Coumadin 4 mg at 8:00 AM and at 5:00 PM, which was not as ordered. The MAR further revealed RN #2 and LPN #1 also administered Coumadin 4 mg at 9:00 PM on both days as ordered. Therefore, Resident #1 received 12 mg of Coumadin per day on two consecutive days (a total of 24 mg) instead of the 4 mg of Coumadin per day as ordered by the physician.

Review of Resident #1's laboratory results on 08/10/12, at 11:56 PM, revealed a critical PT of more than 143 and an INR of 13.75 (reference

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. BUILDING _____ B. WING _____	C 09/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN MANOR OF PAINTSVILLE	1025 EUCLID AVENUE PAINTSVILLE, KY 41240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 6	F 333		

PT of 9.4-11.4 and INR of 1.5-4.5) and the resident was transported to the hospital for evaluation and treatment.

Review of Resident #1's hospital record revealed on 08/11/12, at 2:40 AM, the resident's PT was more than 143 and the INR was 13.75; and the resident's Partial Thromboplastin Time (PTT) (a blood test used to measure the time it takes plasma to clot) was 54.9 (reference of 25.4-33). The hospital record revealed the resident was diagnosed with Coumadin Toxicity and Anemia. The hospital record further revealed Resident #1 received two injections of Vitamin K, five units of packed red blood cells, and two units of fresh frozen plasma. Upon discharge from the hospital the resident's INR decreased from 13.75 to 1.

Interview conducted on 09/25/12, at 4:00 PM, with RN #1 revealed the RN administered Coumadin 4 mg on 08/09/12 and 08/10/12, at 8:00 AM and 5:00 PM, to Resident #1. The RN stated she "found it odd" when administering Coumadin at 8:00 AM, because Coumadin usually was administered around 5:00 PM; however, the RN did not check the physician's order prior to administration of the Coumadin at 8:00 AM on 08/09/12 and 08/10/12. RN #1 also stated she had never in 12 years of nursing administered Coumadin twice a day to the same resident; however, she again administered Coumadin 4 mg at 5:00 PM to Resident #1. The interview revealed when the electronic MAR highlighted the Coumadin 4 mg as being due at 8:00 AM and 5:00 PM, she checked to make sure it was the correct dose for Resident #1 but did not check the frequency on the medication label as per policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. BUILDING _____ B. WING _____	C 09/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN MANOR OF PAINTSVILLE	1025 EUCLID AVENUE PAINTSVILLE, KY 41240

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F 333	Continued From page 7 Interview conducted on 09/26/12, at 10:30 AM, with the Administrator and the Director of Nursing (DON) revealed nurses were trained on how to correctly enter medication orders in the computer system and had to pass a competency skills test prior to working on the floor. The DON verified the pharmacy had filled the new medication order for Coumadin 4 mg and the medication container was labeled as ordered to be administered every night. Interview conducted on 09/26/12, at 2:15 PM, with Resident #1's physician revealed he was notified Resident #1 was admitted to the hospital due to Coumadin toxicity, as a result of being administered too much Coumadin. *The facility implemented the following actions to correct the deficiency: - Resident #1's responsible party was notified of the critical PT/INR and that the resident was being transported to the hospital for evaluation and treatment on 08/11/12. - A Medication Error Report was completed by the Charge Nurse and the Medical Director/Resident #1's primary physician was notified of the error on 08/13/12. - An investigation was initiated on 08/13/12, by the DON when informed Resident #1 was admitted to the hospital for Coumadin toxicity, which consisted of record review and interviews. - The Administrator, the Assistant Administrator, and the DON met on 08/13/12, and discussed the	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. BUILDING _____ B. WING _____	C 09/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN MANOR OF PAINTSVILLE	1025 EUCLID AVENUE PAINTSVILLE, KY 41240

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F 333	Continued From page 8 problems identified from the investigation and developed a corrective action plan. - On 08/13/12 and 09/19/12, the DON and Charge Nurse reviewed all the Coumadin orders to ensure the orders were entered into the MARs computer system correctly and verified the residents had current PT/INR values that were within an acceptable range. No other residents were identified to be affected. - The Electronic Medical Records, the Medication Administration, and the Anticoagulant Therapy policies were reviewed by the Administrator, the Assistant Administrator, and the DON on 08/13/12, with revisions made to the Anticoagulant Therapy policy. The revision added that when writing a telephone order for such medications as Coumadin, the nurse should have a second nurse check the order to ensure accurate transcription and computer input. - Disciplinary warnings and re-education were given to LPN #1 and RN #1 on 08/15/12, by the Administrator, the Assistant Administrator, and the DON. - All written telephone orders were again reviewed to ensure the orders were accurately entered into the electronic computer system by the Charge Nurse on 09/19/12. - All written telephone orders will be reviewed daily to ensure the orders were accurately entered into the electronic computer system by the DON, Assistant DON (ADON), Charge Nurse, or the Assistant Administrator on Monday through Friday, and by the MDS nurses on Saturday and	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. BUILDING _____ B. WING _____	C 09/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN MANOR OF PAINTSVILLE	1025 EUCLID AVENUE PAINTSVILLE, KY 41240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 9	F 333		

Sunday. The daily reviews will be documented on a new Continuous Quality Indicators (CQI) assessment tool which was developed on 09/20/12. Any medication errors identified during the daily reviews will be investigated and corrected immediately by the staff performing the review. A Medication Error sheet will be completed and reviewed as part of the CQI meeting. The nurse responsible for the error will be re-educated at the time the error is identified. Any other errors will be documented on a pink Defective Documentation sheet which will detail the error. The sheet will be given to, and discussed with, the nurse responsible and then signed by the nurse and given to the DON.

- The DON will utilize the daily reviews, Medication Error sheets, and Defective Documentation sheets to track errors on an individual basis to assist in identifying areas of weakness for individual staff re-education purposes. The DON will maintain a file for each nurse which contains these documents in order to track/trend educational needs.

- An in-service was conducted on 09/19/12, by the DON for all licensed nurses regarding Coumadin side effects, entering orders into the computer system, utilizing the correct time code in the computer, medication administration, and verifying orders for such medications as Coumadin with another nurse.

- The facility has a CQI meeting scheduled for 09/28/12, to discuss the correction plan, along with the CQI assessment tool and the tracking/trending of the Defective Documentation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. BUILDING _____ B. WING _____	C 09/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN MANOR OF PAINTSVILLE	1025 EUCLID AVENUE PAINTSVILLE, KY 41240

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F 333	Continued From page 10 **The surveyor validated the corrective actions taken by the facility as follows: - Interview with Resident #1's responsible party on 09/25/12, at 12:30 PM, and review of Resident #1's medical record verified nursing staff notified the responsible party of the critical PT/INR, that the resident was being transported to the hospital for evaluation and treatment on 08/11/12, and that the resident had received more Coumadin than ordered by the physician. - Interviews conducted on 09/26/12, with the DON at 10:30 AM, and the Medical Director/Resident #1's physician at 2:15 PM, and review of the Medication Error Report revealed the Charge Nurse completed the report and notified the Medical Director/Resident #1's primary physician of the error on 08/13/12. - Interviews with the Assistant Administrator on 09/25/12, at 4:00 PM, and with the Administrator and DON on 09/26/12, at 10:30 AM, and review of the facility's investigation regarding Resident #1's Coumadin toxicity revealed a complete and thorough investigation was conducted by the DON. - Interview with the DON on 09/26/12, at 10:30 AM, and a review of a pharmacy list of all residents who were administered Coumadin, revealed the DON reviewed all the Coumadin orders to ensure the orders were entered into the MARs computer system correctly and verified the residents had current PT/INR values that were within an acceptable range per physician on 08/13/12 and 09/19/12. No other residents were identified to be affected.	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 333	Continued From page 11 - Interviews with the Assistant Administrator on 09/25/12, at 4:00 PM, with the Administrator and DON on 09/26/12, at 10:30 AM, and with the Medical Director at 2:15 PM, and review of the Electronic Medical Records, the Medication Administration, and the Anticoagulant Therapy policies revealed the policies were reviewed by the Administrator, the Assistant Administrator, and the DON on 08/13/12, and dated as reviewed with revisions made to the Anticoagulant Therapy policy. The revision added when writing a telephone order for such medications as Coumadin, the nurse should have a second nurse check the order to ensure accurate transcription and computer input. - Interviews on 09/25/12, with the Assistant Administrator at 4:00 PM and RN #1 at 5:00 PM, and on 09/26/12, with LPN #1 at 9:50 AM and the Administrator and DON at 10:30 AM, and review of documentation revealed disciplinary warnings and re-education were given to the RN and LPN on 08/15/12, by the Administrator, the Assistant Administrator, and the DON. - Interviews with the Administrator and DON on 09/26/12, at 10:30 AM, and review of documentation revealed all written telephone orders were reviewed to ensure they were accurately entered into the electronic computer system by the Charge Nurse on 09/19/12. - Interviews on 09/25/12, with the Assistant Administrator at 4:00 PM and with the Administrator and DON on 09/26/12, at 10:30 AM, and review of documentation revealed beginning 09/19/12, all written telephone orders	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. BUILDING _____ B. WING _____	C 09/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN MANOR OF PAINTSVILLE	1025 EUCLID AVENUE PAINTSVILLE, KY 41240

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F 333	Continued From page 12	F 333		

were reviewed daily to ensure they were accurately entered into the electronic computer system by the DON, Assistant DON (ADON), Charge Nurse, or the Assistant Administrator on Monday through Friday and by the MDS Nurses on Saturday and Sunday. The interviews and documentation review revealed a new Continuous Quality Indicators (CQI) assessment tool was being utilized. The interviews also revealed medication errors identified during the daily reviews would be investigated and corrected immediately and a Medication Error sheet would be completed and reviewed as part of the CQI meeting. According to the interviews, the nurse responsible for the error would be re-educated at the time the error was identified. Further interviews and documentation review of the Defective Documentation sheet revealed a copy of the sheet would be given to the nurse responsible for the error and discussed with the nurse, and then given to the DON. The interviews and documentation revealed the DON will maintain a file for each nurse which contains these documents in order to track/trend educational needs.

- Interviews on 09/25/12, with the Assistant Administrator at 4:00 PM and RN #1 at 5:00 PM, and on 09/26/12, with LPN #1 at 9:50 AM, with RN #2 at 10:20 AM, and with the Administrator and DON at 10:30 AM, and review of documentation revealed all licensed nurses were in-serviced by the DON regarding Coumadin side effects, entering orders into the computer system, utilizing the correct time code in the computer, medication administration, and verifying orders for such medications as Coumadin with another nurse was completed on 09/19/12.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. BUILDING _____ B. WING _____	C 09/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN MANOR OF PAINTSVILLE	1025 EUCLID AVENUE PAINTSVILLE, KY 41240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE